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ABSTRACT

Clinical approaches to child sexual abuse have been constrained by limited knowledge of the family dimensions of the problem. This study compared the psychiatric responses of women with and without sexual abuse histories to disclosures of their children's sexual abuse, and assessed the relationship of these histories to the nature of the child's victimization. A cohort of sexually abused children was followed at three points up to a year's interval after disclosure with measures of maternal and child victimization experiences, changing psychiatric symptoms, life stresses, and family structure. Children (N=49) and their mothers (N=44) were recruited from a pediatric hospital emergency department and from district attorneys' offices. Sixteen mothers reported having been sexually abused in childhood. Maternal and child psychiatric symptoms were assessed. Mothers who had been sexually abused differed significantly from those who had not with regard to their children's abuse, which was more severe, more frequently intrafamilial, and more often involved force. They also differed significantly regarding their own psychiatric response profiles, which showed no decline over time. The duration of the mother's victimization in childhood was strongly associated with the perpetrator's use of force on the child. The mother's child abuse experiences were associated both with the nature of their children's abuse experiences and with their own responses to the disclosure of these experiences. (LLL)

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Dual Vulnerability of Sexually Victimized Mothers and Sexually Victimized Children: A Longitudinal Study

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ABSTRACT

Objective.--To compare the psychiatric responses of women with and without sexual abuse histories to disclosures of their children's sexual abuse and to assess the relationship of these histories to the nature of the child's victimization.

Design.-- A cohort of sexually abused children was followed at three points up to a year's interval after disclosure with measures of maternal and child victimization experiences, changing psychiatric symptoms, life stresses and family structure.

Setting.--Forty-nine children and their mothers were recruited from a pediatric hospital emergency department and from district attorneys' offices.

Participants.--The children were aged 6 through 12, 72% female, and were victims of severe sexual abuse. Sixteen mothers reported having been sexually abused in childhood.

Main Outcome Measures.--Maternal and child psychiatric symptoms were assessed by Brief Symptom Inventory, Child Behavior Checklist, Revised Manifest Anxiety Scale, and Children's Depression Inventory.

Main Results.--Mothers who had been sexually abused differed significantly from those who were not with regard to their children's abuse (more severe, more frequently intrafamilial, more often involving force) and their own psychiatric response profiles (no declines over time). The duration of the mother's victimization in childhood was strongly associated with the perpetrator's use of force on the child.

Conclusions.--Mothers' child sexual abuse experiences are associated both with the nature of their children's abuse experiences and with their own responses to the disclosure of these experiences. Diagnosis and treatment of child sexual abuse should systemically acknowledge this dual vulnerability.

Clinical approaches to child sexual abuse have been constrained by limited knowledge of the family dimensions of the problem. The management of individual cases is affected by a paucity of understanding of maternal psychological responses and their implications for women's abilities to give support and care to their children.

Only recently has a literature begun to document a psychological impact on mothers of their children's sexual victimization.[1-6] Clinicians have characterized the responses as fitting within the domains of clinical depression and of adult Post-Traumatic Stress Disorder, with artifacts of avoidance and terror, feelings of shakiness, irritability, loneliness, and inability to get close to people, and outbursts of anger.[7,8] Studies of maternal support of sexual abused children have noted mood and behavioral changes in women who believed their children were telling the truth about the abuse, including sleep, appetite, and somatic complaints and recurrent crying; more severe psychopathology has been associated with women who appear to lack a capacity to support their victimized children.[9,10]

Society's reactions to mothers whose children have been victimized by others may be harsh, and the role of mothers in protecting their children may be sharply questioned in current pediatric and protective service agency practice, especially as the management of child sexual abuse has become criminalized in the last decade.[11] The search for adults to punish for children's victimization often appears to take priority over helping parents in distress, as noted in a recent authoritative commentary on the state of the child protection system.[12]

As social welfare agencies have been obliged to coordinate, if not to subordinate, their services to the functions of prosecutors, the giving of support to families, a traditional objective of child welfare work, has become in many places a secondary objective to identifying and convicting the ostensible perpetrators of a child's abuse. In jurisdictions where budgetary pressures have led to reductions in protective agency capacity, the service orientation may be minimal. The identified purpose of child protection work may be simply to protect the child and to punish the offenders, and practitioners may despair of the value of the agencies to which child abuse cases are

reported.[13,14] Clinicians must consider the meaning to mothers both of their children's disclosures and of the agencies which intervene in their and their children's lives.

In this context, mothers may be simply perceived as active or passive instruments in their children's victimization. Their own realities and needs may be ignored, and their capacities to give care to children may be attacked in custody initiatives and criminal actions.[15]

We have reported elsewhere a study of women's psychiatric responses to their children's disclosures of sexual abuse which suggest that mothers should be acknowledged and treated as victims, too.[16] If and when women are treated more solicitously, we suggested, addressing their own needs will enhance their and others' tasks of protecting their children. Another example of a more expansive conception of work with mothers in current practice on child abuse is the growing acknowledgment of the association between the physical abuse of women and children.[17] Ignoring the personal and protective needs of a battered woman may increase the abuse risk of her child.

Related to these gaps in the philosophical and scientific base for clinical practice and social policy are methodological limitations of existing research. Two issues in particular have restricted knowledge of the full impact of child sexual abuse. The first difficulty is the emphasis on mothers' reports of children's responses to victimization.

Nearly all of the research on the impact of child sexual abuse on children focuses on the children's own psychological responses to the victimization, and indeed demonstrates substantial and often lasting psychiatric consequences[18-21]. Most or all of the information about the children in these studies derives from interviews of the mother. Her own emotional state and the meaning of her own victimization history is commonly overlooked. The widespread use in research and clinical practice of measurements which use maternal report exclusively to characterize children's psychological functioning, without validation in direct report or observation of the child, limits and probably skews the data on outcome.[22-24]

The second methodological point is related to the cross-sectional nature of most of the outcome research. In these studies, inferences are drawn

about cause and effect relationships from history and observations collected at single points in time. Such cross-sectional studies cannot nearly sufficiently measure processes of adaptation and change and the complex and nuanced interrelationships of experience, emotional response, development, and repair which characterize mothers' and children's responses to major life crises.[25,26]

This investigation attempts to address both of these methodological shortcomings of previous work on child sexual abuse outcome by focusing specifically on mothers' response patterns, taking into account their own child sexual victimization histories, their children's experiences and responses to abuse, and their relationships to kin and other loved ones, and their family structure. As described in our previous paper, separate assessments of mother's and children's self-reports of the children's emotional responses were employed to discern discrepancies in the maternal characterizations of their children's responses.[16] A longitudinal design addresses the evolving psychological status of mothers and children were repeated at three points over a year's interval following the disclosure of victimization. This paper presents data on the subset of 16 women

who were themselves sexually abused in childhood.

METHODS

Sample

Children aged 6 through 12 years who suffered sexual abuse substantiated by protective services were recruited with their mothers from the Children's Hospital Emergency Department and from district attorneys' offices in greater Boston. Of the 77 families contacted by letter of introduction and telephone request, 49 (64%) agreed to participate. Children with major physical or mental disabilities were excluded from study.

There were no significant differences in socioeconomic status, race, age or gender in the children whose parents did and did not choose to participate, based on the comparison of anonymous background data collected on all families who were contacted.

At the time of initial personal contact, a detailed consent form was signed both by the child and mother. The median interval between the sexual abuse report and the first interview was 9 weeks.

From a sample of 49 children, 2 mothers were eliminated, 1 of whom was an unrelated foster mother whose foster child was abused, and another the mother of two subject children who could only be counted once. Three mothers did not report whether or not they had been sexually abused. Of the remaining 44 mothers or maternal caregivers (2 were custodial stepmother and custodial grandmother), 16 (36%) reported histories of child sexual abuse. The demographic attributes of the sample are summarized on Table 1.

(Insert Table One About Here)

Measures

Interviews at recruitment, and at 6 and 12 months following the first interview were conducted by teams of 2 women with backgrounds in social work, psychology, or special education, who administered the measures summarized on Table 2.

(Insert Table Two About Here)

All measures were read to the women and children in order to minimize the extent to which reading ability might distort the responses.

Maternal psychiatric symptomatology was derived from the General Symptom Index (GSI), a summary scale derived from the Brief Symptom Inventory (BSI), a 53-item questionnaire which describes adult psychiatric symptoms and their severity.[27] Norms for this widely used instrument are available for the general population and for psychiatric

inpatients and outpatients. We employed T scores for normal respondents for this analysis. Clinical cutoffs established by the author of the GSI were also used. Extensive study has been made of the validity and reliability of the instrument. On the General Symptom Index, test-retest and internal consistency reliability range from .80 to .90; the BSI discriminates clinical from nonclinical samples very well.

The children's psychiatric symptomatology was assessed both by direct study and by maternal report. The direct measures used were the Children's Depression Inventory (CDI) and the Revised Children's Manifest Anxiety Scale (RCMAS).[28-31] Each are widely used self-report measures in which the child is asked to respond to specific statements, e.g. in the CDI to select a sentence which best describes feelings in the last 2 weeks: "I am sad once in a while. I am sad many times. I am sad all the time," or in the RCMAS to answer yes or no to such statements as "I worry about what is going to happen."

In measuring depression, a score from 0 to 2 is derived from each statement on the CDI, and adding the responses gives a "depression score." Likewise,

an anxiety score is drawn from added positive responses on the RCMAS, which also contains a so-called "lie scale" to discern subjects who overrespond to questions in a positive direction. The standard T score was used for this analysis. The validity and reliability of the CDI and RCMAS have also been extensively studied.[32,33]

The Child Behavior Checklist (CBCL) was employed to give a maternal report of child functioning, because of its wide use, established validity and reliability, and logical organization.[34] Its "problem scales" characterizing Total Behavior, Internalizing Behavior, and Externalizing Behavior were used here. (The Internalizing dimension describes artifacts of anxiety, depression, somatization, and social withdrawal. The Externalizing dimension conduct disturbances: aggression, hyperactivity, and delinquency.

Notwithstanding the extensive body of research on the CBCL, low levels of correlation of reports of child behavior between parents and children and between parents and professionals have drawn into question the accuracy of parental report measures generally, and of the CBCL particularly.[9,22,35] Especially because of its wide use in the study of

the developmental impacts of child sexual abuse, discrepancies between the CBCL and CDI and RCMAS were given particular attention in this study, as we noted in a separate report[16], with each CBCL finding compared to a direct child report.

Maternal victimization was assessed by direct interview of the mother, in which questions were posed about whether the mother had been sexually abused as a child, by whom, at what ages, by what acts, and over what interval of time.

Stressful life events were measured using Straus and colleagues' adaptation of the Holmes and Rahe stress scales, a widely used measure.[36,37]

Stability of instruments

Test-retest reliability was established as follows to assure the stability of measures as applied in the entire sample of mothers and children: over the 12 months of study, the stability of the General Symptom Index was .73; of the Children's Depression Inventory .51; and of the Revised Children's Manifest Anxiety Scale .47. Test-retest reliability on the Child Behavior Checklist was .68 for behavioral scores over the 12 months; .66 for

internalizing scores; and .78 for externalizing scores.

Statistical Analyses

To measure the associations of maternal symptom scores with demographic, victimization, child outcome, and psychiatric treatment variables, Spearman correlations, Fisher exact tests, and Mann-Whitney U and their associated P values were used as appropriate to the instruments and subject numbers. To compare maternal symptom levels at the 12-month follow-up interval with the initial interview results, multiple methods were employed: paired sample t-tests were used to compare symptom scores at the initial and 12-month interviews; slopes of recovery were calculated from linear regression equations employing scores from all 3 data points; then t-tests were used to compare the slopes to zero (for no change).

RESULTS

Maternal Victimization History

The 16 women suffered childhood victimizations which were often prolonged and severe. The age at which

the abuse began ranged from 6 to 17; the mean age was 11. Intercourse, defined as vaginal or anal penetration, was part of the abuse for 12 of the women (75%). The duration of the abuse ranged from a single incident to 8 years; the average duration was 21 months.

The perpetrator was a family member in 11 cases (69%) and a father or father figure (stepfather or mother's partner) in 5 (32%).

Maternal Victimization and Psychiatric Response

The 16 victimized women expressed psychiatric symptoms significantly above the mean of the General Symptom Inventory at all three points of observation. The findings are summarized on Table 3. At the outset, the mean score was 60.1 (standard error 3.4); at 6 months, the mean score was 58.2 (s.e. 3.7); at 12 months, the mean score was 57.2 (s.e. 2.4). Supporting this impression of sustained psychiatric distress, when the GSI slopes between observation points were calculated and compared to zero, the t test was non-significant (2-tailed $t=-.99$; $p<.34$; 15 d.f.), indicating no significant improvement over the 12-month interval.

(Insert Table Three About Here)

By contrast, GSI means for mothers without histories of sexual abuse declined from a mean score of 57.4 at the outset (s.e. 2.63) to a mean of 50.3 at 6 months (s.e. 2.6), and to a mean of 50.4 at 12 months (s.e. 2.3). This apparent improvement was tested by comparing the GSI slopes to zero; the changes were highly significant (2-tailed $t=3.42$; $p<.003$; 25 d.f.). Where at the initial interview, the GSI scores of mothers with and without sexual abuse histories did not differ from one another (Mann Whitney U $z=-.75$; p=n.s.), at the 12-month followup, the mean scores differed between the 2 groups ($z=-1.88$; $p<.06$).

In order to explore the contributions to the sexually abused mothers' scores on the General Symptom Inventory of specific attributes of their childhood victimizations, each experience was tested against each GSI score at each observation point. Only the age at which the mother was first abused associated significantly with GSI score (at the initial interview $r=.5$; $p<.06$ and at the 6-month

interval, r=.8; p<.006). If she were older at the time of abuse, the risk of a sustained psychiatric response appeared to be greater.

When the contributions both of maternal age and of having experienced anal or genital intercourse to GSI score was tested in multiple regression analyses, significant associations were perceived both at the initial interview and at 6 months (at initial interview r=.67; p<.03; at 6 months r=.80; p<.03). Thus, being older when abused was related to greater emotional distress, even when controlling for severity of the abuse. Notably, of the 5 women in this sample who had experienced psychiatric hospitalization, all had been sexually abused in their childhoods. None of the mothers without sexual abuse histories had been psychiatrically hospitalized in their pasts. This difference is highly significant (Fisher's exact test, 2-tailed, p<.004).

Maternal victimization and child victimization

Compared to the children whose mothers were not sexually abused in childhood, children of victimized mothers were abused more seriously. This impression generalized to all the measured dimensions of the

children's victimization: severity (Mann Whitney U $z=2.39$; $p<.02$), force ($z=1.63$; $p<.10$), duration ($z=1.88$; $p<.05$), whether the abuse included genital intercourse ($X^2=7.111$; $p<.008$), whether the abuse was intrafamilial ($X^2=4.243$; $p<.04$), and whether there were multiple abuses of the child (Fisher exact test, 2-tailed; $p=.002$).

Whether the nature of the child's victimization affected the extent of the relationship between a maternal history of abuse and the mother's psychiatric symptoms after disclosure was explored in multiple regression analyses. Neither the duration nor the use of force in the child's abuse appeared to exert an effect independent of the mother's abuse history. Whether the child's abuse was intrafamilial also did not appear to contribute to the victimized mother's psychiatric responses. A marginal relationship was found, however, with the presence of intercourse in the child's abuse and the severity of the mother's psychiatric symptoms at the 12-month interval (Mann Whitney U $z=-1.82$; $p<.07$).

One specific aspects of the mother's own victimization, its duration, was strongly associated with the nature of the children's abuse experience. The longer the mother's abuse, the greater the

likelihood that force would be used in the abuse of the child ($r=.70$; $p<.002$).

Maternal victimization and child symptomatology

The mother's reports of child behavioral distress did not in general distinguish the women who had been victimized in childhood, except at the 12-month interval, where a relationship was perceived between a mother's victimization history and her report of more severe child behavioral symptoms on 2 subscores of the CBCL, the child behavioral score (Mann Whitney U $z=2.061$; $p<.04$) and the internal score (Mann Whitney U $z=2.36$; $p<.02$).

Maternal History and Family Structure

We classified family structure into three types (whether the mother was alone, partnered, or married) and compared them at the time of the child's abuse and at the three study intervals. At the time of the abuse 17 of the mothers were alone (36%), 15 (32%) were married, and 8 (17%) were living with a partner to whom they were not married. By the 12 month interview, 18 (42%) of the mothers were alone, 15 (35%) were married, and 5 (12%) were partnered. Among the sexually abused women, the

greater duration of the mother's sexual abuse in childhood was consistently and strongly associated with the mother's being involved with a partner to whom she was not married at the time of the abuse and at both the initial and 12-month interviews (respectively Mann Whitney U $z=2.12$; $p<.03$; $z=1.86$; $p<.06$; $z=2.41$; $p<.02$).

Comparing the current family structures of mothers who had been sexually abused with those who were not yielded only a single significant difference: the mothers with sexual abuse histories were more likely to be living with a partner at the 12-month interview (Mann Whitney U $z=-2.03$; $p<.05$).

But several associations were noted between family structure and the psychiatric response profiles when the entire sample was examined. If a woman was living alone at the 12 month interview, she was substantially more likely to have a high GSI score (Mann Whitney U $z=2.31$; $p<.02$). No such relationship was perceived among women who were partnered but not married ($z=1.35$; $p<.18$), and women who were married appeared to be <u>protected</u> against the most serious emotional impacts.

If mothers were married there was a strong negative

relationship with GSI score at the 12-month interview ($z=2.43$; $p<.02$). When on multiple regression analysis effects of GSI scores at the initial interview were controlled, significant relationships remained between family structure and GSI scores at the 12-month interview. When these relationships were examined separately for mothers with and without sexual abuse histories, we found that these relationships only applied for women who reported no sexual victimization in childhood. For sexually abused women, family structure did not predict GSI scores at the 12-month interview.

Maternal History and Support of the Child

Support of the child, as measured by the mother's belief of the child's disclosure and participation in recommended treatments, did not distinguish mothers who had been sexually abused in childhood from mothers who were not. Indeed, a maternal victimization history was associated significantly with the total number of child psychotherapy treatment contacts (Mann Whitney U $z=1.83$; $p<.06$)and with the number of group treatment contacts ($z=2.13$; $p<.04$).

Stressful Life Events

The sexually victimized mothers' psychiatric distress was also reflected in their reports of stressors in their lives. In comparison to the entire sample of mothers, sexually victimized and not, whose total stress scores decreased significantly from the initial to the 12-month interviews (paired t test $t=3.57$; $p<.0009$), mothers with histories of sexual abuse generally had sustained high levels of stress, attaining statistical significance in 2 subscales having to do with housing crisis associated with foreclosure of their homes (Fisher exact test, 2 tailed, $p<.04$) and with the occurrence of injury in their households ($p<.006$).

The preponderance of the women with sexual abuse histories were poor (11 of the 16 or 69% were in SES groups 4 and 5 versus SES groups 2 and 3, in contrast to 12 of the 28 or 43% of the women with no sexual abuse histories)($X^2=2.736$; $p<.10$), suggesting an abiding impact of chronic life stress which would not have been measured on the life events scales.[38]

DISCUSSION

A mother's sexual victimization appeared to exert serious impacts both on mothers and on their sexually abused children. Both with regard to the women's own psychiatric response profiles and to the severity of the children's sexual abuse experiences, the maternal history had burdensome implications. Exactly how the experience of child sexual victimization translates to the later vulnerability of women and their children is unknown, but these data offer leads for theorizing on the personal implications of victimizing experiences in childhood and their consequences for family formation and for the protection and care of children. In previous studies, child and adult victims of abuse have been noted frequently to experience a powerlessness which may linger long after the victimization experience.[39] This sense of being in thrall to others and without capacity to turn the course of one's life is believed by many scholars to determine the later vulnerability of victims to subsequent exploitation at the hands of others, including battering men and rapists.[40,41]

This study is limited in its capacity to define the extent to which antecedent sexual victimization may

have been associated with maternal psychiatric symptoms and vulnerabilities prior to the disclosure of the child's victimization. As well, the absence of a comparison group of women whose children had not been sexually abused may limit its ability to control whatever confounding may be attributable to this stressful personal experience. Current adult victimizations of these women, say, by battering men, were also not measured. The small size of the sample of women who were victimized in childhood, further limits both the extent to which confident inferences and generalizations may be drawn from their post-disclosure psychiatric data.

With these caveats in mind, we propose that it is useful to separate the hypothesized impacts of the experience of child sexual victimization from the psychiatric responses a mother may experience after a disclosure of victimization by a child. The mother's own abuse, we suggest, may be expressed in a panoply of troubles. These may include vulnerabilities in the domain of interpersonal relationships and the capacity to people would be hurtful to herself and her children and to protect against them.

In comparison to the children of women who were not

sexually victimized in childhood, these women's children suffered abuses which were substantially more severe, suggesting that the perpetrators of the offenses were people of unusually violent proclivities. The concept of coercive control is finding wide use in studies of the dynamics of battering relationships, and child sexual victimization is increasingly understood less as an issue of deviant sexual expression than as a manifestation of disturbed power relationships in family life, where a man will use a variety of physical, sexual, and emotional coercions to assure his superordinate position.[42] Both women and children, then, may be vulnerable to domination by intrusive men, a dual vulnerability which may be associated with the woman's childhood victimization experience.

We would propose from this set of connections that child sexual abuse in subsequent generations may be partly or largely explained by the enduring impacts of coercive control and powerlessness in one's early years. Maternal powerlessness deriving from protracted abuse in childhood may be associated with later relationships of a coercive and intrusive nature. Support for such a formulation is suggested by the finding that the longer the mother's

childhood abuse endured, the greater the likelihood that force would be used in the abuse of her child.

The sexually victimized mother's psychiatric response profiles appear to suggest that the experience of learning of one's child's victimization may have a qualitatively different personal meaning for them than for mothers who were not victimized in childhood. The persistence of high levels of symptomatology suggests that there is something profoundly distressing and unbalancing in this experience.

For women who were victimized in childhood, neither lines of support nor an island of safety may be found in her own family in the face of such a crisis. A richly metaphorical characterization of the impact for one woman was given in a moving passage from "The Courage to Heal," a popular self-help guide for women who have been sexually abused:

"My own healing came to a screeching halt when I heard about my daughters. The pain of that whole thing, I don't know how to describe it. I just felt so much worse about them than I did about me. That's the trap you're in as a mother. I felt flattened by

the news. It just knocked me out. I didn't have the umph left to deal with my own abuse.

These men, starting with my father, were stealing my childhood, and were stealing my children's childhood, and were stealing everything about us, even our memories. I felt like there was some big force trying to obliterate us from the earth. It was all one great big river of male abuse. We were all just tumbling down the rapids together, and there was no possible way I could separate myself from them, because they were littler and they were going to drown sooner."[43] (pp. 283-284)

This powerful statement captures the concept of powerlessness and connects it to sensations of profound turmoil and emotional uprooting in the face of inexorable external forces.

We find useful the formulation of post-traumatic stress disorder (PTSD) in organizing and comprehending these data. It is notable that PTSD can occur immediately or after substantial periods of time, and that the syndrome is described in the Diagnostic and Statistical Manual of Psychiatric Disorders as a response to events which the individual himself or herself may suffer, or as a

consequence of injury to that person's loved ones.[44] Symptoms in adults suffering from PTSD include repeated thoughts and dreams about the trauma, which may often intrude on daily consciousness and experience; numbed emotional responses; avoidance of experiences which may remind the person of the traumatic event; and manifestations of increased arousal, including vigilance, problems in sustained addressing of tasks, and sleep disturbance.

Recent work on the prevalence of PTSD suggests it is a reasonably frequent phenomenon. In one study of one thousand young adults, 39.1 percent had been exposed to a traumatic event at least once in their lives, and 23.6 percent of them developed PTSD. The lifetime prevalence of PTSD is estimated at 9.2 percent in the sample.[45] Women were noted to be more vulnerable than men were to PTSD when they saw someone else being seriously hurt or killed, or when they heard news of a violent death of a loved one or friend. Subjects who developed PTSD after a traumatic event were noted to have a high prevalence of previously existing anxiety disorders (75.3%) and family histories of anxiety.

That the child's victimization is directly reminiscent of their mothers' childhood abuse

experience suggests a quite specific triggering of PTSD for them. Although we could not specifically measure maternal psychiatric status prior to the child's sexual abuse, we believe it is appropriate to presume, given current studies of the impacts of sexual abuse on children, that these women were vulnerable to later traumata.[20,26,40,41]

Our understanding of mothers' responses and children's vulnerability is also helped by the developing research literature which takes a life span developmental perspective on stress and trauma.[46-49] Single traumatic events, investigators have noted, may set the stage for more elaborated responses to subsequent traumatic experiences.[50,51] These may include a broader range of reactions (or "stress responses"), a more prolonged period of subsequent distress and of diminished resiliency, and they may be associated with diminished coping capacities in other family members.[52,53] Serious adult psychiatric disturbance may be often associated with repeated traumatic exposures.[54]

For sexually victimized women whose children are sexually abused, there are at least two substantial life traumas with which to contend, their own abuse and their child's. Because the latter may also be

associated with a strong sense of betrayal by their partners or by others who had access to their offspring, just as the mother's expectation of the caring role of adults was betrayed in her own childhood, the child's victimization can be understood as an equivalently serious second insult. There is, of course, no way to quantify the comparative impacts of such experiences; we wish simply to underscore the need for clinicians and others to take a developmental perspective on adult traumas and their implications for children and family life.

The married mothers in this study appear to have been somewhat protected against the second trauma. Such support may serve importantly to buffer the effects of severe life stress. Conversely, there is wide agreement among scholars of social support about the risks which are attached to isolation, especially when contending with stressful life events.[55-57]

Being partnered did not appear to help the mothers in this study; it appears to be a separate and different circumstance, with its own risks. The state of partnership, furthermore, may not be intermediate between being alone and being married.

Implications for practice

In all cases involving an allegation of child sexual abuse, women should be interviewed about their own histories of victimization. Women who have such histories should be especially seriously prepared for the personal psychological consequences of the disclosure, and where indicated, referrals for psychiatric treatment of the women and children should be made. In these conversations, we believe it is quite important not to criticize, implicitly or explicitly, the capacity of the victimized mother to give care to her children. Neither should her psychiatric distress, which may manifest in the period immediately after the child's own disclosure of victimization, be interpreted as a sign of her having failed to protect the child or having in some way colluded with the person who may have victimized the child. Although such situations certainly occur, the priority here attaches to getting child and mother both to the specialized services which will allay the impacts of the trauma.

Given the importance of a mother's history of child sexual victimization in defining the course of her psychiatric response to her child's victimization,

it is entirely possible that in other conditions in which the disclosure of a child's traumatic experience, or the diagnosis of a serious illness, presents a crisis for a family, a mother may be vulnerable to an adverse psychiatric reaction. In these situations, too, we suggest, it may be appropriate to inquire about the mother's own childhood experience of victimization, to comprehend her reactions to current events with sympathy for her past experience, and to help her appropriately to contend with present events.

CONCLUSION

The emotional burdens of a maternal history of child sexual abuse appear to be substantial, continuous, and connected to children's vulnerability. Professionals have an opportunity at the time of a child's disclosure of victimization to attend to the family dimensions of this problem. The understanding of the long reverberations of childhood trauma should stimulate a rethinking of the significance of the disclosure of child sexual abuse to the family in the process of development.

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TABLE 1

Demographic Attributes

ATTRIBUTE	MOTHERS WITH ABUSE HISTORIES N=16	MOTHERS WITHOUT ABUSE HISTORIES N=28
	Mean (SD)	Mean (SD)
Age	33.6 (5.5)	34.6 (7.18)
SES	3.9 (1.15)	3.4 (1.2)
Child's Age	8.8 (1.7)	8.6 (1.9)
	Percent (Number)	Percent (Number)
Child's Gender		
Female	87.5 (14)	60.7 (17)
Male	12.5 (2	39.3 (11)
Race		
White	68.75 (11)	78.6 (22)
Black/Hispanic	31.25 (5)	21.43 (6)
Mother Married		
Time of Abuse	25 (4)	35.7 (10)
Time One	12.5 (4)	32.1 (9)
Time Three	18.8 (3)	42.3 (11)
Mothers Partnered		
Time of Abuse	18.8 (3)	14.2 (4)
Time One	12.5 (2)	10.7 (3)
Time Three	25 (4)	3.8 (1)
Mother Alone		
Time of Abuse	43.8 (7)	67.9 (19)
Time One	62.5 (10)	35.7 (10)
Time Three	43.8 (7)	42.3 (11)

TABLE TWO

MEASURES

Method of Administration	Measure	Variables
Maternal Report	Brief Symptom Inventory	Maternal Psychological Symtomatology
	Child Behavior Check List	Child Symptoms
	Victimization	Maternal and Chi Victimization Experiences
	Stressful Events	Life Stresses
Child Self-Report	Revised Children's Manifest Anxiety Scale	Child's Symptom: Anxiety
	Children's Depression Inventory	Child's Symptom: Depression

TABLE 3

Psychological Status of Mothers
With and Without Sexual Abuse Hostories

	WAVE 1 Mean (SE)	WAVE 2 Mean (SE)	WAVE 3 Mean (SE)	Paired T Test For Differences Between Wave 1 and Wave 3	
Mothers With Sexual Abuse Histories	60.1 (3.4)	58.2 (3.7)	57.2 (2.4)	t=.992	p<.34
Mothers Without Sexual Abuse Histories	57.4 (2.63)	50.3 (2.6)	50.4 (2.3)	t=3.4	p<.003